Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

CLIENT STATEMENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

CLIENT STATEMENT

I (1) _____ hereby consent of my own free will to be sterilized by (2) _____
Individual to be sterilized *Physician*

by a method called (3) _____ My consent expires 180 days from the date of my signature below. I
Specify type of operation

also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funding by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(4) _____ (5) _____
Signature *Month Day Year*

You are requested to supply the following information, but it is not required. *Race and ethnicity designation (please check):*

☐ American Indian or Alaska Native ☐ Black (not of Hispanic origin) ☐ White (not of Hispanic origin)

☐ Asian or Pacific Islander ☐ Hispanic

INTERPRETER'S STATEMENT (To be used if an interpreter is provided to assist the individual to be sterilized.)

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to
Language
him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ _____
Interpreter *Date*